

Household food insecurity, diet quality and obesity: an explanatory model

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Keywords: Food insecurity, distress, emotional eating, BMI, diet

Running title: Household food insecurity, diet and obesity

Word count: 3767

Funding: The research reported in this manuscript was funded by a local pump-priming grant from N8 AgriFood awarded to Charlotte A. Hardman.

Disclosure: CAH and PC receive research funding from the American Beverage Association for work outside of the submitted manuscript. CAH has also received speaker fees from International Sweeteners Association.

Study Importance Questions

What is already known about this subject

- Food insecurity (a lack of stable access to nutritious food) is reliably associated with obesity and a less nutritious diet but the underlying mechanisms are not yet clear.
- Research has identified links between food insecurity and increased distress, and between distress and maladaptive coping mechanisms (e.g. eating to cope). However, no studies to date have explored whether household food insecurity might be associated with elevated BMI via the mediating pathway of increased distress and eating to cope.

What are the new findings in your manuscript

- Household food insecurity was indirectly associated with higher BMI via greater experienced distress and the use of food as a coping mechanism.
- Food insecurity was directly associated with poorer diet quality, but this relationship was not explained by distress and eating to cope

How might your results change the direction of research or focus of clinical practice?

- Interventions seeking to reduce obesity prevalence in food-insecure populations will likely benefit from targeting sources of distress and subsequent coping mechanisms.
- Further investigation of the psychological mechanisms that might drive eating behaviour in response to household food insecurity will be of benefit in the future.

Abstract

Objectives: Food insecurity (a lack of stable access to nutritious food) is reliably associated with poor diet, malnutrition and obesity; however, the underlying mechanisms are unclear. Here, we tested the hypothesis that these relations are explained by higher levels of distress, due to experiencing food insecurity, and unhealthy coping behaviours (eating high-calorie foods, drinking alcohol).

Methods: Adults from the United Kingdom (N = 604), recruited online and at food banks, completed questionnaire measures of: household food insecurity, physical stress, psychological distress, eating to cope, drinking to cope, diet quality and self-reported height and weight to calculate body mass index (BMI).

Results: Structural equation modelling was used to test the hypothesised relationships, including a multilevel structural model controlling for the effect of income. As predicted, food insecurity was indirectly associated with higher BMI via greater distress and eating to cope. Food insecurity was directly associated with poorer diet quality, but this relationship was not explained by distress and eating to cope

Conclusions: Our data provide novel insight into the psychological experience of being food-insecure and how maladaptive coping mechanisms might play some role in the association between food insecurity, diet and obesity.

Introduction

Food insecurity refers to unreliable access to nutritionally adequate and safe foods, which is usually the result of a lack of financial resources. On a global scale, over 2 billion people are estimated to experience food insecurity, including 8% of the population in North America and Europe, with this number currently rising (1). In addition to food insecurity being associated with many non-communicable diseases (2, 3), it is a robust predictor of obesity in children and adults (4).

According to the Insurance Hypothesis, greater fat storage occurs in response to food insecurity because this is an adaptive strategy to protect against starvation (5). Indeed, in non-human animals, fat reserves have been shown to increase under conditions of food restriction (5). However, it is unclear how increases in body fat are achieved when access to food is limited or unpredictable (6, 7).

In humans, the greater availability of low-cost, energy-dense foods in neighbourhoods where food insecurity is high is thought to play a key role in the association between food insecurity and BMI (8, 9). Food insecurity is also robustly associated with anxiety and depression (10, 11), and emotional distress may be fundamental in explaining the relationship between socio-economic disadvantage and obesity (12, 13). Emotional distress is associated with increased food intake and higher body mass index (BMI) (14, 15). More specifically, individuals may seek to alleviate distress through maladaptive coping behaviours such as eating energy-dense palatable foods or consuming alcohol. Consistent with this, lower socio-economic status is indirectly associated with higher BMI via increased emotional distress and subsequent emotional eating (16). While socio-economic disadvantage and food insecurity are closely related, they are distinct constructs (17, 18), and the potential for psychological distress and unhealthy coping behaviours to explain the food-insecurity-obesity association has not been examined previously.

In the current study, we collected primary data and used structural equation modelling to test a theoretical model of the associations between household food insecurity (HHFI), poor diet quality and obesity. Distress plays a central role in the model and was operationalised as both physical symptoms of stress (including wear and tear on the body, or ‘allostatic load’) and psychological distress (depression, stress, anxiety). Maladaptive coping via eating unhealthy foods and drinking alcohol were included as both are associated with more frequent consumption of unhealthy foods and increased BMI (15, 19, 20). Adults from the United Kingdom completed online questionnaire measures of the target constructs.

We predicted that HHFI would be indirectly associated with higher BMI and poorer diet quality via distress and subsequent eating and drinking to cope. Specifically, greater HHFI would be associated with greater distress (emotional and physical stress); greater distress would be associated with greater eating and drinking to cope; and greater eating and drinking to cope would be associated with higher BMI and poorer diet quality.

Methods

Participants

Individuals were recruited via (i) visits to food banks in the city of Liverpool (North West of the UK), (ii) a database of individuals who had given consent to be contacted about University research studies, and (iii) adverts on social media (Facebook) targeted at individuals aged between 18-75 years and living within a 25-mile radius of the city of Liverpool. As reimbursement for time and effort to complete the questionnaires, participants were anonymously entered into a prize draw to win shopping vouchers (1 x £100, 1 x £50, 2 x £25 prizes). Based on the formula by (21) a minimum of 467 participants was needed to observe a close fitting RMSEA ($df = 24$, $\alpha < .05$, 90% power). We rounded this up to 500 and

aimed to recruit over this number to account for any incomplete responses. Ethical approval for the study was granted by the University of Liverpool's Research Ethics Committee.

Measurements

Demographic information: Participants reported their age (in years), gender, ethnicity, and the first three characters of their post code. Total household income (9-point scale: 1 = < £5 200, 2 = £5 200 - £10 399, 3 = 10 400 - £15 599, 4 = £15 600 - £20 799, 5 = £20 800 - £25 999, 6 = £26 000 - £36 399, 7 = £36 400 - £51 999, 8 = £52 000 - £77 999, 9 = ≥£78 000) and highest level of education (8-point scale: 1 = none, 2 = GCSE grade D or below, 3 = GCSE grade C or above, 4 = A-level or equivalent, 5 = university degree or equivalent, 6 = postgraduate qualification or equivalent, 7 = Masters or equivalent, 8 = PHD or equivalent.) were reported using ordinal scales. They also reported their employment status (employed full-time, employed part-time, unemployed looking for work, unemployed not looking for work, retired, student, unable to work due to health or disability, housewife/husband, voluntary employment), the number of adults living in their household (including themselves) (options: one, two, three, four, five, six or more) and the number of children (under 18 years of age) living in their household (options: none, one, two, three, four, five, six or more).

Body Mass Index (BMI): Participants provided self-reported height (in feet and inches, or centimetres) and weight (in either kilograms or stones and pounds). BMI (kg/m^2) was computed using the formula $\text{weight}(\text{kg})/(\text{height}(\text{m}) \times \text{height}(\text{m}))$. Self-reported BMI has been shown to be highly correlated with objectively-measured BMI (22, 23).

Household Food Insecurity (HHFI): The United States Department of Agriculture Household Food Security Survey Module was used (24) to quantify difficulties experienced by individual households over the past 12 months in obtaining a sufficient amount of

nutritionally adequate food. Participants completed a total of 10 questions from modules 1, 2, and 3. Answers of “often true” “sometimes true”, “almost every month”, “some months but not every month”, and “yes”, were coded as 1 and all other responses as zero. The sum of positive responses reflects household food insecurity with scores ranging from 0 (low food insecurity) to 10 (very high household food insecurity).

Psychological distress: The 21-item self-report Depression, Anxiety, and Stress Scale (DASS) (25) was administered (Response options: 0 = Never, 1 = Sometimes, 2 = Often, 3 = Almost always). Cronbach’s Alpha values for each of the three subscales were: depression $\alpha = .93$, anxiety $\alpha = .84$, stress $\alpha = .88$, overall distress scale $\alpha = .95$.

Physical symptoms of stress: Participants reported the extent to which nine symptoms of physical stress had troubled or distressed them during the past month (e.g., sleep problems, headaches, constant fatigue / feeling run down). Responses ranged from 0-4, with 0 being “not been bothered at all” and 4 “extreme bother”. Scores were averaged across items with higher scores indicating greater symptoms of physical stress. For the current data $\alpha = .83$.

Allostatic load: Participants were asked about having elevated blood pressure, elevated blood glucose, and if they were currently taking medication to lower their cholesterol (response options: “yes” or “no”). Responses were coded as 1 (yes) or 0 (no). These items have been shown to be strong predictors of allostatic load (26). Participants were also asked how many times they had visited a medical General Practitioner for themselves in the last month (“never”, “once”, “twice”, “three times”, “four times”, “five times or more”). Responses scored as 1 (never) to 6 (five times or more). These scores were then summed.

Eating to cope: The coping subscale from the Palatable Eating Motives Scale was used, which has good internal reliability and validity (27). It consists of five items (e.g. “How often do you eat tasty foods to forget about your problems?”) (Response options: “Never / Almost

Never”, “Some of the time”, “Half of the time”, “Most of the time”, “Almost always / Always”). Scores were averaged across items with higher scores indicating higher levels of the behaviour. For the current data $\alpha = .92$.

Drinking to cope: The three items from the coping subscale of the abbreviated Drinking Motives Questionnaire were used, which has good reliability and validity (28). Participants read the statement “Thinking of all the times you consume alcohol, how often would you say that you drink for each of the following reasons?” (e.g. “To forget about your problems?”) Responses were on a 5-point scale (“Never / Almost Never”, “Some of the time”, “Half of the time”, “Most of the time”, “Almost always / Always”). Scores were averaged across items with higher scores indicating higher levels of the behaviour. For the current data $\alpha = .86$.

Diet quality: Diet quality was assessed via a short food frequency questionnaire taken from the Yorkshire Health Survey (29). Participants rated the frequency with which they consumed the following: wholemeal bread, white bread, crisps, fried chicken, processed meats, beer, wine, sugary drinks, oily fish, and other fish (“More than once a day”, “Once a day”, “4-6 times a week”, “2-3 times a week”, “Once a month”, “Less than once a week”, “Never”). Abbreviated food frequency questionnaires of this kind have been shown to have good reliability and validity (30). Participants were also asked how many portions of fruit and vegetables, excluding potatoes, they ate on a typical day (“none”, “one”, “two”, “three”, “four”, “five or more”). Scores for crisps, white bread, fried chicken, processed meats, and sugary drinks were all coded as: More than once a day = 1 to Never = 7, while scores for fish and oily fish were reverse scored (i.e. More than once a day = 7, Never = 1). Daily fruit and vegetable consumption were counted as portions per day (none = 1 to five or more = 6). Scores for: white bread, crisps, fried chicken, processed meats, sugary drinks, oily fish (reverse scored), fish (reverse scored), fruit and vegetables were then summed with low values representing poorer diet quality.

Procedure

The questionnaires were hosted online via Qualtrics (SAP, Washington). Participants recruited via online methods (e.g., advertisements on social media) accessed the questionnaire via a web link. Participants recruited at foodbanks (approximately 5% of total sample) were approached with an electronic tablet connected to the internet or they were provided with paper copies of the questionnaire depending on their preferred completion method. All participants read an information sheet and provided written informed consent followed by the questions on demographic information, height and body weight. The following questionnaires were then presented in a randomised order: DASS, symptoms of physical stress, allostatic load, household food insecurity, eating to cope, drinking to cope, and diet quality. Finally, participants were debriefed and given the option to be entered into the prize draw to win shopping vouchers.

Planned analyses

A structural equation model was created to test the hypothesis that HHFI would be indirectly associated with higher BMI and poorer diet quality, via distress and maladaptive coping mechanisms (eating to cope and drinking to cope). All modelling was conducted in MPLUS version 8.4. A total of 759 responses were initiated but only 606 completed all fields necessary to complete the analyses. A further two cases were removed for providing unfeasible weight values $\leq 34\text{Kg}$ (31), therefore responses from 604 participants were included in the analyses.

Due to the non-normality of household food insecurity, eating to cope, drinking to cope and BMI, a maximum likelihood estimator with a Santorra-Bentler correction was used

for model fitting (32). A range of fit indices were produced to test the models. The standardised root mean residual (SRMR) absolute fit was computed with values under 0.08 being indicative of good fit. Two baseline comparisons, the Tucker Lewis index (TLI) and Comparative Fit Index (CFI) were deemed as being acceptable at above .90 and good at above .95 (33). Finally, the root mean square error of approximation (RMSEA) parsimony adjusted measure is reported with values less than 0.06 being good fit and values greater than 0.06 but less than 0.08 being acceptable (33).

Before running the model, the effects of gender and age on each variable in the model were investigated via correlations and independent samples t-tests. Where gender or age had a statistically significant influence, they were included as covariates in the model.

Results

Descriptive statistics

The sample ($N=604$) was mostly female (90%) and white (96%); 47.2% were full-time employed, 20.5% were part-time employed, 32.3% were unemployed, retired, students, in voluntary work or identified as housewives/husbands; 58.8% had achieved an undergraduate degree or higher. The level of moderate food insecurity (defined as providing a positive response to three or more instances of food insecurity on the United States Department of Agriculture Household Food Security Survey Module) was 21.5%, which is higher than the typical 6-10% reported in the United Kingdom (1). In terms of living circumstances, 22.5% were the only adult in the household, 53.6% lived with one other adult, 23.9% with two or more adults; 62.6% had no children under the age of 18 in the household, 18.5% lived with one child, and 18.9% with two or more children; 41.2% had an annual

household income of less than £25,999 per annum, 19.4% earned between £26,000 and £36,399, 19.4% between £36,400 and £51,999 and 20% over £52,000 per annum. Of the sample, 22.8% ate five or more portions of fruit and veg a day, and mean BMI (\pm SD) was 29.19 (\pm 7.86) kg/m² (scores >25 indicative of being overweight), with 2.8% of the sample classified as underweight, 30.8% of healthy weight, 28.6% with overweight and 37.8 % with obesity. See Table 1 for further details.

INSERT TABLE 1

Three separate measurements of distress were taken; (i.) physical symptoms, (ii.) psychological symptoms using the Depression, Anxiety and Stress (DASS) scale (24), and (iii.) allostatic load. A confirmatory factor analysis (CFA) was performed which showed that each measurement had a highly significant loading onto the latent variable ‘distress’ (β s>.74, p s<.001). The overall fit of the model was good to acceptable (CFI = .99_{sb}, TLI = .99_{sb}, RMSEA_{sb} = .066, SRMR = .01). When allostatic load was included, the model still showed a good fit, but the individual loading of allostatic load was substantially lower (β = .237, p <.001) than all other variables. Therefore, allostatic load was not included in the final latent factor.

Model evaluation

INSERT FIGURE 1

The final model (Figure 1) was a good to acceptable fit for the data ($CFI_{sb} = .95$, $TLI_{sb} = .91$, $RMSEA_{sb} = .072$, $SRMR = .032$). A covariance was added between eating to cope and drinking to cope based on modification indices. Direct associations between the variables and hypothesised indirect effects are shown in Tables 2 and 3, respectively. For ease of interpretation, the values in Figure 1 are standardised (beta) coefficients whereas those in Table 2 are regression coefficients.

INSERT TABLE 2

Household food insecurity (HHFI), BMI and diet quality

As can be seen in Table 2, HHFI was directly associated with distress, drinking to cope and poorer diet quality but it did not directly contribute to eating to cope or BMI. There were no direct associations between distress and diet quality or BMI.

Consistent with predictions, distress was directly associated with increased eating to cope which in turn was associated with increased BMI, although the association between eating to cope and poorer diet quality was not statistically significant. Distress was also associated with elevated drinking to cope which, although not associated with diet quality, did have a marginal association with (lower) BMI.

Indirect effects were calculated for the hypothesised effect of HHFI on BMI and diet quality through distress and eating or drinking to cope (while controlling for other variables in the model; Table 3). The hypothesised indirect effect via distress and eating to cope was

significant for BMI but not for diet quality. There was a marginal indirect effect through distress and drinking to cope on (lower) BMI but not on diet quality

INSERT TABLE 3

Secondary analysis

In order to control for the effect of income on the model, we ran a multilevel structural model (MLSEM) with the levels of weekly household income added as a random intercept (<£100, $N=21$; £100-199, $N=43$; £200-299, $N=48$; £300-399, $N=45$; £400-499, $N=77$; £500-699, $N=110$; £700-999, $N=110$; £1000-1499, $N=82$; £1500+, $N=32$). The smaller sample ($N=568$) in this analysis is due to 36 participants not reporting household income.

This approach enabled us to explore the effects in the model at the lower level (participants) controlling for the higher level (income). Income was not instead added as a predictor in the model due to collinearity with HHFI and ordinal measurement (necessitating generalised modelling). In addition, we were only interested in ascertaining whether the associations in the model held after controlling for income, taken together this made the MLSEM the most appropriate analysis.

The model after controlling for income was a good fit (lower level SRMR =.038). The pattern of results (Table 4) was almost the same as the single level model (Table 2). It is notable that after removing variance associated with income there was no direct association between drinking to cope and BMI, nor between HHFI and drinking to cope.

INSERT TABLE 4

Discussion

The current study tested a novel theoretical model in which distress and unhealthy coping behaviours are intervening variables which explain the well-established associations between household food insecurity (HHFI), poor diet quality and obesity. For the first time, we show that HHFI is indirectly associated with higher body weight via greater distress and eating to cope (i.e., HHFI was associated with distress; distress was associated with eating to cope; eating to cope was associated with higher BMI). Importantly, these associations remained in the multi-level model which controlled for participants' level of income. This indicates that the effects are specific to HHFI rather than it acting as a proxy for more general socio-economic disadvantage.

Our data provide new insight into the 'food-insecurity-obesity paradox' by providing a behavioural mechanism for how increases in body fat may be achieved under conditions of food insecurity (5-7). Our findings are also consistent with contemporary models of obesity and recent empirical data in which distress and unhealthy coping behaviours are central to explaining the association between socio-economic disadvantage and obesity (12, 13, 16). Notably, in our model, distress was not directly associated with higher BMI; the indirect effect required the addition of eating to cope. This suggests it is not distress *per se* but people's coping responses which drive the association between HHFI and BMI. In line with this, previous studies have found that stress alone does not account for the relation between social disadvantage and obesity (7, 34). Maladaptive coping mechanisms involving food thus appear to be critical.

Our finding that HHFI was directly associated with poorer diet quality is well-established (35, 36); however, contrary to prediction and our findings for BMI, this

relationship was not explained by distress and eating to cope. One possibility is that eating as a coping mechanism is more strongly associated with larger portion sizes and binge eating (37) as opposed to frequency of intake *per se* of unhealthy foods. Further research is needed to understand specific patterns of eating which are associated with food insecurity and obesity. In the single-level model, there was also a significant indirect effect of HHFI via distress and drinking to cope on *lower* BMI. Given the strong associations between alcohol and disease burden, especially in socially disadvantaged groups (38), further consideration of motivations for alcohol use in the context of HHFI is warranted. However, the direct association between drinking to cope and lower BMI was no longer statistically significant in the multi-level model which controlled for participants' level of income.

Our findings have practical implications for interventions and policy agendas to tackle HHFI. Transitioning people to more healthy and sustainable plant-based diets and reducing socio-economic inequities in diet-related non communicable diseases, including obesity, is high on international agendas (1, 39). However, to effectively intervene and change consumer behaviour, it is critical to first understand the broader context and drivers of dietary intake in populations characterized by high levels of HHFI. Interventions must also be tailored to the needs of high-risk groups (40). Whilst environmental and socio-economic characteristics such as food availability, price and socio-cultural norms in addition to individual-level factors (e.g. knowledge and attitudes) are known to be important drivers of dietary inequalities (8, 9, 41), our data highlight the need to consider and target distress and unhealthy coping behaviours. Provision of psychological support to reduce distress and support the development of positive coping strategies may be an effective intervention strategy. The necessity of these interventions is all the more timely in the light of the COVID-19 global pandemic in 2020 which increased household food insecurity, widened inequalities in access to safe, nutritious foods, and had a profound impact on mental health (42, 43).

Our study recruited a broad spectrum of participants, including those who were visiting food banks to ensure sufficient representation of individuals experiencing HHFI. However, the data are cross-sectional therefore it is not possible to infer direct causal relations between variables; longitudinal datasets will be informative on this issue. The relationships between variables are relatively modest, which likely reflects the myriad of factors that influence the association between food insecurity and eating behaviour (e.g. exercise, genetic factors) (e.g. 5, 8, 9). Future research should include such variables to establish how they influence the relationships observed in this study. Furthermore, recent data indicate that weight gain in food-insecure humans is explained by increased absorption of energy from food (i.e., energetic efficiency) rather than increased intake (6). Future research should therefore consider these alternative pathways which link HHFI with higher body weight. Because the sample was predominantly female (90%), it was not possible to test the gender differences observed in previous studies (5, 44) whereby food insecurity is associated with higher BMI in females but not males. However, gender was controlled for in the model. Our sample was also predominantly white and it is not clear if the same pathways and associations would exist across all ethnic groups. Finally, although the hypotheses and analyses were based on previous research (16) they were not formally pre-registered, and pre-registration is recommended for future studies in this area to enhance transparency and reproducibility (45).

Conclusion

In this study of UK-based adults, we show that HHFI was indirectly associated with higher body weight via greater distress and eating to cope. HHFI was directly associated with poorer diet quality, however this relationship was not explained by distress and eating to cope.

Interventions seeking to reduce obesity prevalence in food-insecure populations will likely benefit from targeting sources of distress and subsequent coping mechanisms.

Acknowledgements

The authors thank Dr Christian Reynolds and Dr Neil Boyle for advice on the measures of diet quality and symptoms of stress, respectively, and Professor Jason Halford for helpful comments on an earlier draft of the manuscript.

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Figure 1. Associations between household food insecurity and BMI and diet quality via distress (latent variable), eating and drinking to cope. For ease of interpretation, error terms and covariances are not visually represented (Values are standardised regression coefficients)

* $p < .025$, ** $p < .001$. The dashed line between diet quality and BMI represents co-variance.

Table 1. Sample descriptives and questionnaire scores (N = 604)

	Mean	Standard deviation	Range
Household food insecurity ^a	1.78	2.82	0-10
DASS – Depression ^a	27.59	10.62	14-56
DASS – Anxiety ^a	23.59	8.42	14-54
DASS – Stress ^a	30.36	9.35	14-56
Physical stress symptoms ^a	2.73	.86	1-5
Allostatic load ^a	1.96	1.19	1-8
Eating to cope ^a	2.11	1.02	1-5
Drinking to cope ^a	1.63	.82	1-5
Diet quality ^b	36.88	6.66	13-52
BMI kg/m ²	29.19	7.86	15.0-66.8
Age (y)	39.07	12.66	18-75

Note. BMI = Body Mass Index, DASS = Depression Anxiety Stress Scale.

^a A high score represents greater symptoms i.e. of food insecurity, psychological and physiological stress

^b Low scores represent more frequent consumption of processed foods and less fresh produce

Table 2: Direct associations between variables

Association	B (SE)	p	95% CI
HHFI → Distress	0.51 (.06)	<.001	0.40 to .62
HHFI → Eating to cope	0.06 (.08)	.441	-0.10 to 0.22
HHFI → Drinking to cope	0.11 (.05)	.017	0.02 to 0.20
HHFI → BMI	-0.05 (.12)	.675	-0.28 to 0.18
HHFI → Diet quality	-0.47 (.10)	<.001	-0.65 to -0.28
Distress → Eating to cope	0.68 (.08)	<.001	0.53 to 0.83
Distress → Drinking to cope	0.16 (.04)	<.001	0.08 to 0.23
Distress → BMI	-0.05 (.10)	.969	-0.23 to 0.24
Distress → Diet quality	-0.13 (.09)	.176	-0.31 to 0.06
Eating to cope → BMI	0.39 (.07)	<.001	0.24 to 0.53
Eating to cope → Diet quality	-0.12 (.06)	.070	-0.24 to 0.01
Drinking to cope → BMI	-0.30 (.12)	.015	-0.55 to -0.06
Drinking to cope → Diet quality	-0.09(.11)	.378	-0.30 to 0.11
Gender* → Eating to cope	1.38 (.61)	.023	0.18 to 2.56

*Males (0) Females (1) NOTE: The association (covariance) between BMI and diet quality was significant (B -5.05 SE= 1.94, p=.009)

Table 3: Hypothesised indirect effects

Association	B (SE)	p	95% CI
HHFI → Distress → Eating to cope → BMI	0.13 (.03)	<.001	0.07 to 0.20
HHFI → Distress → Eating to cope → Diet Quality	-0.04 (.02)	.076	-0.08 to 0.01
HHFI → Distress → Drinking to cope → BMI	-0.03 (.01)	.034	-0.05 to <-0.01
HHFI → Distress → Drinking to cope → Diet Quality	-0.01 (.01)	.388	-0.03 to 0.01

Table 4: Direct associations between variables from the MLSEM

Association	B (SE)	p	95% CI
HHFI → Distress	0.41 (.06)	<.001	0.29 to 0.53
HHFI → Eating to cope	0.10 (.07)	.112	-0.02 to 0.23
HHFI → Drinking to cope	0.12 (.07)	.068	0.01 to 0.23
HHFI → BMI	-0.05 (.22)	.811	-0.48 to 0.31
HHFI → Diet quality	-0.47 (.16)	.003	-0.78 to -0.21
Distress → Eating to cope	0.72 (.07)	<.001	0.58 to 0.87
Distress → Drinking to cope	0.17 (.05)	<.001	0.08 to 0.26
Distress → BMI	0.01 (.17)	.971	-0.33 to 0.34
Distress → Diet quality	0.17 (.16)	.277	-0.47 to 0.14
Eating to cope → BMI	0.38 (.18)	.031	0.03 to 0.73
Eating to cope → Diet quality	-0.13 (.08)	.111	-0.28 to 0.03
Drinking to cope → BMI	-0.24 (.21)	.239	-0.64 to 0.16
Drinking to cope → Diet quality	-0.07 (.07)	.284	-0.21 to 0.06
Gender* → Eating to cope	1.19 (.50)	.023	0.21 to 2.18

*Males (0) Females (1)

